

Peter M. Gutierrez, Ph.D. (moderator), COL Carl A. Castro, Diana J. Fitek, Ph.D., Dave Jobes, Ph.D., and Marjan Holloway, Ph.D.

20 JUNE 2012



COL Carl A. Castro

Chair, Joint Program Committee for Military Operational Medicine (JPC-5)

Director, Military Operational Medicine Research Program (MOMRP)



Scope of the Problem: Suicide in the Military

- Historically, military suicide rates were below civilian rate
- Some initial (still unsupported) hypotheses:
- People at highest risk of death by suicide are not selected for military service?
- Military service itself is a protective factor?
- Absence of standardized data collection on suicides prevented testing of these hypotheses
- Majority of suicide prevention programs and treatments are still not evidence-based
- As military suicide rate surpassed civilian rate, surveillance data and research needed to develop evidence-based interventions were just beginning
- CY2010 Suicide Rates (DoDSER)

Air Force	Army	Marine Corps	Navy
15.5	21.7	17.2	11.1



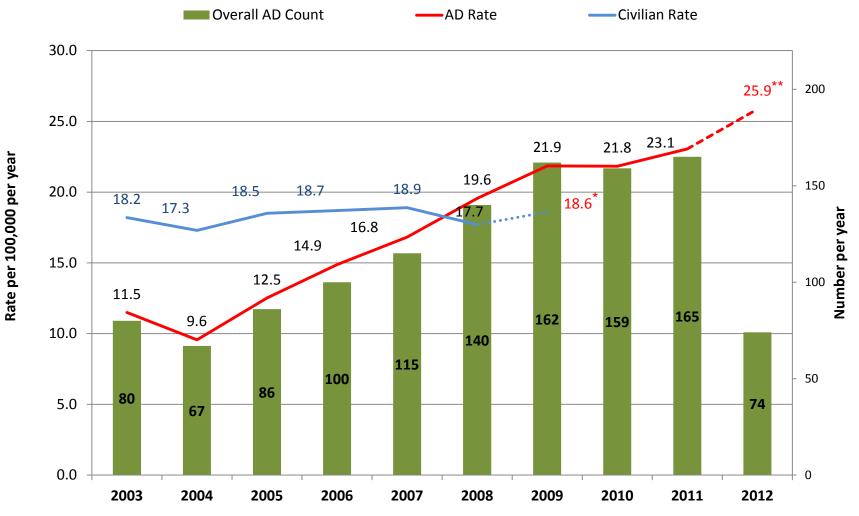
Possible Military Suicide Risk Factors

- Recent failure in spousal or intimate relationship, often in month prior to suicide
- Occupational and/or legal problems
- History of behavioral health disorder, substance abuse (misuse of prescription medication), prescribed psychotropic medication, accessed outpatient behavioral health services in month prior to suicide
- Communicated suicidal ideation to spouse, friend or other family members

(DoDSER, 2010)



Army Active Duty Suicide Deaths



- * = Preliminary Civilian Rate NOT CDC OFFICIAL as of 16 MAR 2011
- ** = Preliminary Army Rate based on end strength of 715,662 as of 25 MAY 2012





Epidemiology / Army STARRS 3 studies, \$62.1N

Basic Science / Neurobiological Mechanisms 1 study, \$3M

RESEARCH NEEDS

Translation and Implementation, Dissemination Continuing Education and Reinforcement for Soldiers, Leaders and Service Providers

- Evidenced-based Suicide Prevention Training
- Population-based Training
- Leader Training

- Validated
- Population-based Screening Measure
- Early Selective Identification Screen & Referral
- Selective Indicated
- Validated Risk
 Assessments
- Imaging & Biomarkers
- Impact of Comorbidities
- Clinical Practice
 Guidelines
- Effective Medications
- Cognitive &
 Behavioral
 Interventions
- Recovery Protocols
- Evidenced-based
 System of Care
 Models
- RTD Standards
- Postvention Care for Service
 Members and
- Families
 Rescreening
- Unit Support

Prevention Education & Training

Early Screening/ Intervention

Assessment

Treatment

Recovery and Return to Duty

Postvention

- Validated Pre-Deployment Training
 Validated Leader Training
- Screening Assessment (Pre-/Post-Deployment)
- Unit Level Screening
- Evidenced-based Clinical Assessments
- Validated
 Protocol to
 Identify High Risk
 Individuals
- Inpatient/ Outpatient Psychotherapies
- Medications
- Follow-up Care for Suicide Attempters/ High Risk Patients
- Outpatient
 Therapy
- Co-Morbidities
- Collaborative Case
 Management
- Outpatient Care
- Evaluation/ Measurement
- Rescreening
- Psychological Autopsy

1 study*

1 study, \$1.1M

3 studies, \$5.5M

12 studies*, \$18.2M

1 study*, \$2.5M

* Funded by Military Suicide Research Consortium (\$17M)

SOLUTIONS / CAPABILITIES

TOTAL ACTIVE: 24 studies, \$110M

Research Investment along Continuum of Care

\$67.5M: Epidemiology/Basic Sciences – Army STARRS, risk factors (Hill), role of deployment on suicidality (Reger), epidemiology of medication abuse and overdose (Cooper), Study to Examine Psychological Processes in Suicidal Ideation and Behavior (STEPPS; O'Connor)

\$5.2M: Prevention, Education & Training – behavioral intervention for insomnia (Bernert), understanding resilience during suicide bereavement (Cerel), caring texts (Comtois), training family members to assist servicemembers in help-seeking (Allen), promoting resilience among family members of high-risk servicemembers (Renshaw), reducing anxiety sensitivity (Schmidt)

\$1.9M: Early Screening & Intervention – development and validation of a theory-based screening process for suicide risk (Vannoy), optimizing screening and risk assessment (Joiner)



Research Investment along Continuum of Care

\$4.2M: Assessment – Use of thermal imaging to assess and optimize level of physiologic arousal during treatment (Familoni), toward a "gold standard" for suicide risk assessment in the military (Gutierrez & Joiner)

\$21.9M: Treatment – Collaborative Assessment and Management of Suicide (Jobes), Window to Hope (Brenner), brief CBT interventions (Bryan, Holloway, Rudd), Virtual Hope Box (Bush), high-dose left prefrontal TMS (George), DBT (Goodman), blister packaging for medication adherence (Gutierrez), safety planning (Holloway), intranasal delivery of biodegradable neuropeptide nanoparticles (Kubek), risk assessment in group therapy (Johnson & Jobes)

\$4.5M: Recovery & Postvention – caring letters intervention (Luxton), development of guidelines and decision aids for evidence-based response to suicidal behavior during deployment (Stanley)



Largest Investments: How Are they Different?

Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)

- \$62.1M (\$50M Army, \$12.1M NIMH)
- Co-Pls Robert Ursano, MD (USUHS) and Murray Stein, MD, MPH (UCSD)
- 5 major studies
 - Historical Data Study
 - All Army Study
 - New Soldier Study
 - Soldier Health Outcomes Study (A & B)
 - Special Studies
 - Pre/Post-Deployment Study
 - Clinical Calibration Study
- Studies mostly Soldiers, some Marines
- Retrospective and prospective epidemiological studies
- Data informs development of interventions

Military Suicide Research Consortium

- \$17M (funded by Defense Health Program)
- Co-led by Peter Gutierrez, PhD (Denver VA MIRECC) and Thomas Joiner, PhD (FSU)
- 7 currently funded studies, 2 additional studies pending
- Studies may involve any service and/or veterans
- Focus on interventions (prevention, screening, assessment, treatment, recovery and postvention)



DoD Suicide Research: Challenges and Successes

- Omega-3 and Tau protein—how relevant are they?
- Importance of establishing and maintaining relationship with command of possible study site
- Multi-site studies needed, complicates an already lengthy IRB approval process
- Army STARRS and MSRC



DoD Suicide Research: The Way Ahead

- Theory-driven, evidence-based treatment studies (in/out patient)
- Research to examine the effects of brief interventions to reduce suicide behavior, problem drinking, and other outcomes (e.g., accidents, homicide, intimate partner violence, etc.)
- Basic science to validate underlying psychological and biopsychological theories of suicide
- Combined psychotherapy and pharmacotherapy treatment studies
- Validate suicide prevention training (universal, at-risk populations)
- Validate objective suicide screening measure(s) for field and clinic use



DoD Research Funding

https://www.usamraa.army.mil/pages/baa_forms/index.cfm

http://www.grants.gov (Search by CFDA number 12.420)

https://momrp.amedd.army.mil/

http://cdmrp.army.mil/

http://www.tatrc.org/about_funding.html

http://www.darpa.mil/Opportunities/Solicitations/DARPA_Solicitations.aspx

http://www.acq.osd.mil/osbp/sbir/

https://www.armysbir.army.mil/



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MILITARY SUICIDE RESEARCH CONSORTIUM

The views expressed are those of the authors and do not represent the Department of Defense, Department of Veterans Affairs, or the US Government



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VISN 19 MIRECC, University of Colorado
School of Medicine
Thomas Joiner, Ph.D., Florida State University
Co-Directors



MSRC Background/Rationale

- Produce new scientific knowledge about suicidal behavior in the military
- Use high-quality research methods and analyses to address problems in policy and practice
- Disseminate knowledge, information, and findings
- Train future leaders in military suicide research



Core A Peer Review MEAB Program (Military External **Executive Management Core Advisory Board) Training & Development Core B** Core C Information **Database/Statistical** Management/ Scientific **Management Core Communications Core** Disseminate to **Decision Makers**

Research Program



Research Program Areas

- Treatment and Case Management
- Screening and Risk Assessment
- Basic Research (includes neurobiology and genetics)
- Prevention
- Postvention



MSRC FUNDED RESEARCH



Military Continuity Project

Texting a brief intervention to prevent suicidal ideation and behavior

Katherine Anne Comtois, PhD MPH

University of Washington Department of Psychiatry



A Behavioral Sleep Intervention for Suicidal Behaviors in Military Veterans: A Randomized Controlled Study

Rebecca Bernert, Ph.D. Department of Psychiatry and Behavioral Sciences



Stanford University Medical Center



Usability and Utility of a Virtual Hope Box (VHB) for Reducing Suicidal Ideation

Nigel Bush, Ph.D.

National Center for Telehealth & Technology
University of Washington



Brief Intervention for Short- Term Suicide Risk Reduction in Military Populations

Craig J. Bryan, PsyD
University of Utah
National Center for Veterans Studies



Development and Evaluation of a Brief, Suicide Prevention Intervention Reducing Anxiety Sensitivity

Norman B. Schmidt, Ph.D.

Florida State University



Window to Hope

Lisa A. Brenner, Ph.D., ABPP

VISN 19 MIRECC



Suicide Bereavement in Military and their Families

Julie Cerel, Ph.D.

University of Kentucky



COLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY SUICIDE STATUS FORM

Lori Johnson, Ph.D.

Louisville VA Medical Center



Toward a Gold Standard Suicide Assessment

Peter M. Gutierrez, Ph.D. VISN 19 MIRECC

Thomas Joiner, Ph.D. Florida State University



MSRC STUDIES UNDER DEVELOPMENT



The Psychophysiology of Suicidal States: Temperamental and Physiologic Suicide Risk Assessment Measures and Their Relation to Self-Reported Ideation and Subsequent Behavior

Michael H. Allen, M. D., University of Colorado School of Medicine, VISN 19 MIRECC

Theresa D. Hernández, Ph.D., University of Colorado, VISN 19
MIRECC



CONSORTIUM WEBSITE

WWW.MSRC.FSU.EDU



The Operation Worth Living (OWL) Project:

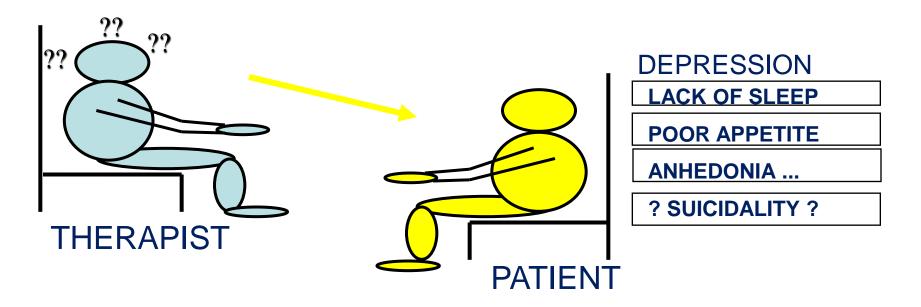
A Randomized Trial of the Collaborative Assessment and Management of Suicidality vs. Enhanced Care as Usual for Suicidal Soldiers

David A. Jobes, Ph.D., ABPP
Principal Investigator
Professor of Psychology
Associate Director of Clinical Training
The Catholic University of America



STUDY BACKGROUND/RATIONALE:

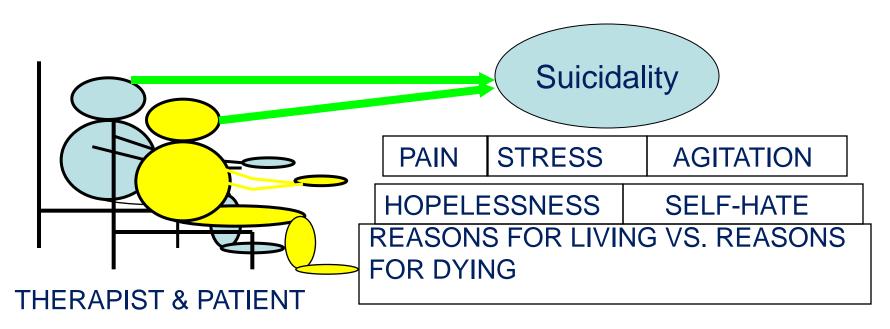
CRITQUE OF THE REDUCTIONISTIC MODEL (Suicide = Symptom of Psychopathology)



Traditional treatment = inpatient hospitalization, treating the psychiatric disorder, and using no suicide contracts...



CAMS targets <u>Suicide</u> as the primary focus of assessment and problem-focused intervention...



The Suicide Status Form (SSF) is used to guide assessment and treatment...

Veterans Health Administration Employee Education System

Suicide Status Form-SSF II-R (Initial Section)

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Y 1	Current Intent	Describe:			
Y 1	Empulsivity				
Y 1	Substance abuse				
Y 1	Significant loss				
Y 2	Interpersonal isolation	Describe			
Y 1	Relationship problems				
Y 1	Health problems	Describe			
Y 2	Physical pain	Describe			
Y 2	Legal problems	Describe			
Y 1	Shame	Describe:			

Section C (Climician): OUTPATIENT TREATMENT PLAN (Refer to Sections A & II).

Problem #	Problem Description	Goals and Objectives Evidence for Attainment	Interventions (Type and Frequency)	# Sessions
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3				
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Clinician Signature	Date	Supervisor Signature	D

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			Suicide Tracking I	form					
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Patient Sign	where		Date C	linician Signature	Date				
		Copyright	David A. Johes, Ph.D. All	Rights Reserved.					

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Section C (Clinician Outcom	w Evaluation):	
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PATIENT'S OVERALL SUIC	DE RISK LEVEL (check one and exp	lain):
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☐ Moderate		
☐ Severe ☐ Extreme		
CASE NOTES (diagnosis, fire	tional risks, treatment plan, symptom	
Next Appointment Scheduled:	Theatment Modelity	
Clinician Signature	Date Super	visor Signature Date

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Evolving Empirical Support for CAMS

Sample/Setting	n=	Significant Results
College Students	106	Pre/Post Distress
Univ. Counseling Ctr.		Pre/Post Core SSF
Air Force Personnel	56	Between Group Suicide
Outpatient Clinic		Ideation, ED/PC Appts.
Danish Outpatients	27	Pre/Post Core SSF
CMH Clinic		Qualitative findings
College Students	55	Linear reductions
Univ. Counseling Ctr.		Distress/Ideation
Danish Outpatients	42	Pre/Post Core SSF
CMH Clinic		
Psychiatric Inpatients	20	Pre/Post Core SSF
		Ideation, Hopelessness
		•
Adult Outpatients (RCT)	32	Ideation/Hope/Distress
	College Students Univ. Counseling Ctr. Air Force Personnel Outpatient Clinic Danish Outpatients CMH Clinic College Students Univ. Counseling Ctr. Danish Outpatients CMH Clinic	College Students Univ. Counseling Ctr. Air Force Personnel Outpatient Clinic Danish Outpatients CMH Clinic College Students Univ. Counseling Ctr. Danish Outpatients 42 CMH Clinic Psychiatric Inpatients 20

Veterans Health Administration Employee Education System

Research AIMS/Hypotheses

- Aim 1: To develop a methodology for identifying, screening, referring to treatment, and tracking distressed Soldiers who admit to being suicidal
- <u>Aim 2:</u> Evaluate whether the organizing of behavioral health care for suicidal Soldiers by CAMS results in a clinically and statistically significant reduction in suicidal behavior and improvement in mental health (e.g., resiliency, hope, reasons for living) as compared to Enhanced Care as Usual (E-CAU).
- <u>Hypothesis 1</u>: At post-treatment and at 3, 6, and 12 months follow-up, CAMS will be more effective in reducing suicidal behavior (suicidal ideation and suicide attempts) than E-CAU.
- <u>Hypothesis 2</u>: At post-treatment and at 3, 6, and 12 months follow-up, CAMS will be more effective in improving mental health (e.g., resiliency, functioning, distress, and psychiatric and health-related symptoms) than E-CAU.
- <u>Hypothesis 3</u>: CAMS provided adherently will be more effective than CAMS at low adherence in reducing suicidal ideation and behavior and improving Soldiers mental health.

<u>Hypothesis 3a (exploratory)</u>: At post-treatment and 3, 6, and 12 months follow-up, CAMS will be more effective in reducing hospitalizations to prevent suicide, emergency department, and medical visits than E-CAU.



Design and Methodology

Consenting Suicidal Soldiers (n=150)

Control Group
E-CAU
3 months of
outpatient care (n=75)

Experimental Group
CAMS
3 months of
outpatient care (n=75)

<u>Dependent Variables</u>: Suicidal Ideation/Attempts, Symptom Distress, Resiliency, Primary Care visits, Emergency Department Visits, and Hospitalizations.

Measures: SSI, OQ-45, SHBQ, SASIC, CDRISC, PCL-M, SF-36, NFI, THI (at 1, 3, 6, 12 months)

Current and Anticipated Challenges

- Delayed start due to IRB process
- Multisite management issues
- IRB management and modifications
- Study transitions and "growing pains"
- Demands on clinic and space issues
- "Store and Forward" adherence/fidelity
- Maintaining command support
- Clinic moving in September 2012
- Staff turn over and additional training



Study Progress

- IRB approval from four different institutions (11 months).
- New CAMS Manual; revised SSF and CAMS Rating Scale.
- Hired Project Coordinator; will hire "back-fill" clinicians.
- Have consented n=4 CAMS and n=4 E-TAU clinicians.
- Experimental arm training conducted 30 April to 2 May.
- Pilot phase of adherence consultation/training has begun.
- We estimate that study patients will be recruited and enrolled in late summer/early fall.



Dissemination/Transition Plan

- We hope to obtain definitive data from a well-powered RCT about the effectiveness of CAMS (note: a well-powered Danish study of CAMS is now underway).
- We will have conducted the study in a real world Army MTF with implications for exportation to other MTF's.
- We will obtain new information about the intervention and CAMS training; we are interested in developing an electronic version of the SSF.
- We ultimately aim to develop a flexible (importable) intervention that will help save Soldiers lives returning them to full duty status with better coping skills and a sense of purpose and meaning—a life worth living.



DoD Funded Inpatient Psychotherapy Randomized Controlled Trials for the Prevention of Suicide

Marjan G. Holloway, Ph.D.

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Uniformed Services University of the Health Sciences



Presentation Outline

Psychiatric Diagnoses

Leading Cause of Military Hospitalizations

Limited Scientific Evidence for Inpatient Care

Post Admission Cognitive Therapy (PACT)

Brief Summary



Psychiatric Diagnoses Leading Cause of Military Hospitalizations



Reasons for Hospitalizations

Table 1. Hospitalizations, ICD-9 diagnostic categories, active component, U.S. Armed Forces, 2005, 2007, and 2009

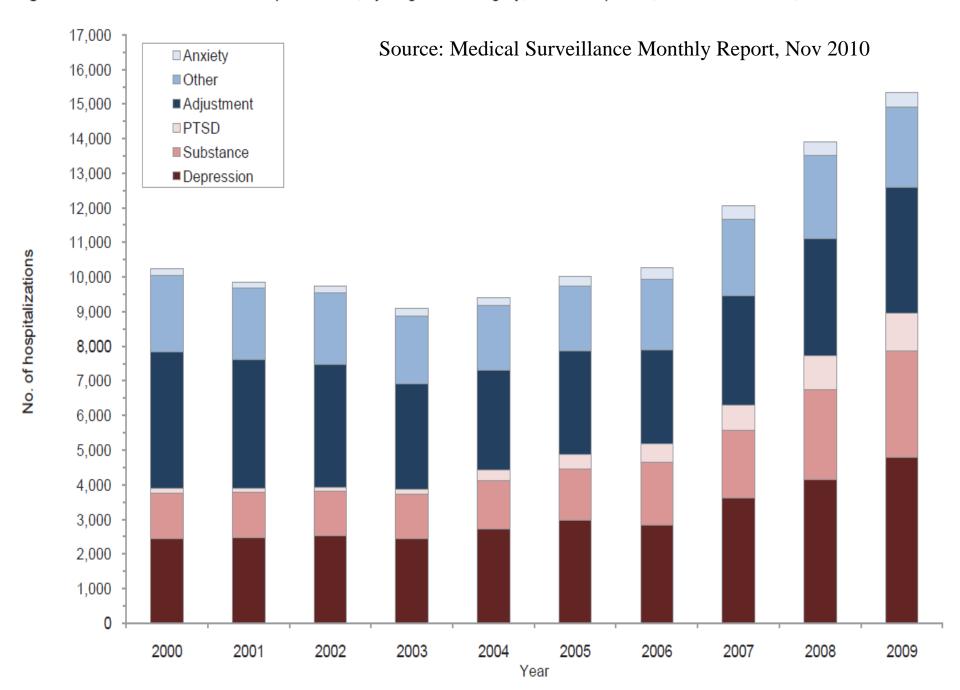
	2005		2007			2009			
Major diagnostic category (ICD-9-CM)	No.	Rate	Rank	No.	Rate	Rank	No.	Rate ^a	Rank
Mental disorders (290 - 319)	11,335	8.01	(3)	13,703	9.78	(2)	17,538	12.13	(1)
Pregnancy and childbirth (630 - 679, relevant V codes) ^b	18,465	13.04 (89.78)	(1)	18,201	12.99 (90.80)	(1)	17,354	12.01 (84.46)	(2)
Injury and poisoning (800 - 999)	12,358	8.73	(2)	12,531	8.95	(3)	11,156	7.72	(3)
Digestive system (520 - 579)	7,332	5.18	(4)	7,373	5.26	(5)	7,676	5.31	(4)
Musculoskeletal system (710 - 739)	7,322	5.17	(5)	7,534	5.38	(4)	7,516	5.20	(5)

Source: Medical Surveillance Monthly Report, April 2010





Figure 1. Mental disorder-related hospitalizations, by diagnostic category, active component, U.S. Armed Forces, 2000-2009



MENTAL HEALTHCARE HISTORY & SUICIDE U.S. ARMY

Psychological Risk Factors Associated With Suicides of Army Soldiers

	2001	-2009	Arm	y	Mortality		
Psychological Risk Factor	N	0/	N	0/.	Rate	Relative	
r sychological Risk Pacior	11 /6	/0	14	/0	Per 100,000	Risk	95% CI

Inpatient care for MH 142 16.2 56,483 1.3 251.4 19.82 16.43–23.91 Outpatient care for MH 400 45.8 678,511 15.5 59.0 4.65 4.17–5.31

Specifically, the relative risk rate for soldiers with a history of inpatient care for any MH diagnosis was 19.82% higher than for soldiers with no history of MH diagnosis, $\chi 2(1, N = 3,754,768) = 1933.64$, p < .001 (Black et al., 2011, p.441).

Limited Scientific Evidence Inpatient Care



Inpatient Psychotherapy RCTs

Study 1 (Liberman et al., 1981)

- 24 Patients Randomized, 2 Yr Follow-up
 Behavior Therapy (n = 12); Insight Oriented Therapy (n = 12)
- 4 Daily Hours of Therapy over 8 Days
- Outcomes: Depression, Suicide Ideation, & Attempts
- BT > IOT at 9 Months

Study 2 (Patsiokas, 1985)

- 15 Patients Randomized, No Follow-up
 Problem Solving (n = 5); Cognitive Restructuring (n = 5);
 Non-Directive Control (n = 5)
- 10 Individual Sessions over 3 Weeks
- Outcomes: Hopelessness, Suicide Ideation, & Intent
- PS > CR = Control



Meta-Analysis of Cognitive-Behavioral Interventions to Reduce Suicide Behavior

Terrier, Taylor, & Gooding, 2008

- 28 Studies
- CBT (includes DBT) versus Control
- Used Suicide Behavior as Outcome



Table 2 Effect Size (Hedge's g), Confidence Intervals, and z Scores Overall and for Six Subgroup Analyses

Adulta Significant		Effect Size and 95% Confidence Interval						Test of Null	
shaward	ests wheren	Data Points	Point Estimate	SE	Variance	Lower limit	Upper limit	(Two-Ti	p p
SIGNIF CONF	Property to	25	-0.591	0.112	0.013	-0.811	-0.371	-5.265	.000
treatmen	Associ tive	7	-0.260	0.192	0.037	-0.635	0.116	-1.355	.175
	The second secon	18	-0.775	0.141	0.020	-1.051	-0.498	-5.497	.000
effeotoga	+ Proceso WILC, or nothing	5	-0.808	0.239	0.057	-1.276	-0.341	-3.389	.001
tica	The state of the s	14	-0.594	0.166	0.028	-0.920	-0.269	-3.574	.000
(Thempy	6	-0.412	0.254	0.065	-0.910	0.087	-1.619	.105
Study focus	Direct	21	-0.712	0.130	0.017	-0.967	-0.457	-5.469	.000
	Indirect	4	-0.228	0.228	0.052	-0.674	0.219	-1.000	.318
Outcome measure	Hopelessness	2	-0.530	0.330	0.109	-1.177	0.116	-1.608	.108
CDT 0 DDT	Satisfaction with life scale	1	-2.585	0.561	0.315	-3.685	-1.484	-4.604	.000
CBT & DBT	Suicide ideation	9	-0.390	0.155	0.024	-0.693	-0.087	-2.522	.012
showed	Suicide, attempt, plan, potential, problem	13	-0.574	0.145	0.021	-0.858	-0.290	-3.957	.000
significant (CBT	18	-0.562	0.132	0.018	-0.822	-0.302	-4.244	.000
_	DBT	7	-0.697	0.228	0.052	-1.143	→0.250	-3.057	.002
	Group	5	-0.263	0.186	0.035	-0.628	0.102	-1.410	.159
CITECIS	Individual	11	-0.576	0.155	0.024	→0.881	-0.271	-3.704	.000
	Individual plus family	2	-0.212	0.325	0.106	-0.849	0.425	-0.652	.514
	Individual plus group	6	-0.790	0.228	0.052	-1.237	-0.343	-3.466	.001
	Telephone plus group	1	-2.585	0.561	0.314	-3.684	-1.486	-4.610	.000

Note: The fully random effects model was used for all analyses. CBT = cognitive-behavioral therapy; DBT = dialectic behavior therapy; TAU = treatment as usual; WLC = waiting-list control.



	Trial 1 Stage I	Trial 2 Stage I	Trial 3 Stage II	Trial 4 Stage II
Total Participants	N = 24	N = 50	N = 218	N = 189
Recruited to Date	21	18	0	49
Funding Source	National Alliance for Research on Schizophrenia & Depression	Congressionally Directed Medical Research Program	United States Department of Defense	United States Department of Defense
Amount	\$60,000	\$457,609	\$6,000,000	\$2,893,708
Inclusion Criteria	Inpatients Suicide Attempt	Inpatients Suicide Attempt AND Trauma	Inpatients Suicide Attempt Past OR Current	Inpatients Suicide Attempt OR Suicide Ideation
Intervention	Post Admissi Treatmer Traur	Safety Planning		

Single versus Multiple Attempt

Sites

Walter Reed National Military Medical Center

To Be Added: Ft. Belvoir Community Hospital

Post Admission Cognitive Therapy (PACT)

Inpatient Cognitive and Behavioral Treatment for the Prevention of Suicide

Cognitive and Behavioral Practice, 2012



Cognitive Therapy for Prevention of Suicide

SUICIDE-RELATED BEHAVIORS

Problematic Coping

Primary Problem
Rather than
Symptom of a
Disorder





Patient's Story

On Decision to Attempt Suicide

I took all the narcotics out that I could find...I laid them all on the bed and I sat there for a couple of minutes and I was thinking, like, it was like a part of me saying, "you don't want to do this." And there was a part of me saying, "Do it. Just do it. Do it." And a part of me saying "oh/no". And it was 3:36 and I was looking at the clock and was just thinking about it – back and forth, back and forth. And 3:40...I was just to do it. And I just grabbed them all and took 'em. And I laid there in bed. I started crying and I don't know why I picked up the phone and I called my brother. I didn't tell him what I did or what was going on, I just called him. And we talked for maybe about a minute or two and hung up the phone. Just waiting. Waiting for the effects to take - for whatever was supposed to happen.

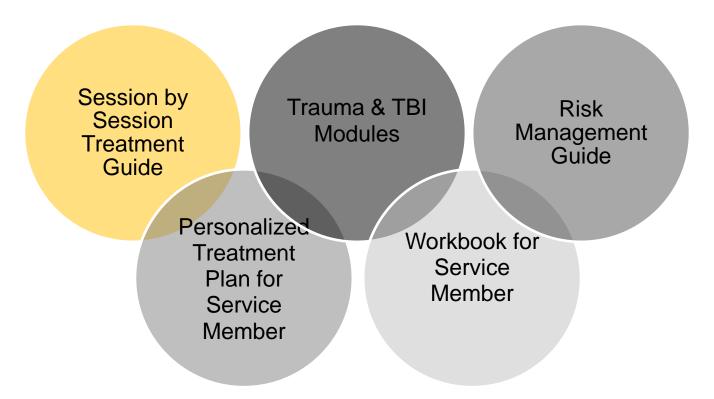


PACT

6 Individual Therapy Sessions – 90 Min Each Sessions Transcribed

Treatment Phase	Therapeutic Goals
Phase I Sessions 1 and 2	 □ Build Therapeutic Alliance □ Provide Psychoeducation □ Collaboratively Plan for Safety □ Develop Suicide Mode Conceptualization □ Assess Readiness for Change
Phase II Sessions 3 and 4	 ☐ Instill Hope – Increase Reasons for Living ☐ Teach Adaptive Coping Strategies ☐ Target Deficits in Problem Solving ☐ Address Social Support Concerns ☐ Practice Emotion Regulation Skills
Phase III Sessions 5 and 6	 □ Promote Linkage to Outpatient Aftercare □ Teach Relapse Prevention Strategies □ Refine Safety Plan before Discharge

Study Deliverables



Summary

Psychiatric hospitalizations provide us with a unique opportunity to provide much needed care for military personnel.

We need to develop evidence-informed interventions for military personnel admitted for inpatient care.

We need to develop these interventions as soon as possible to address the unique needs of this highly vulnerable group.















































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Questions?

